MED - Waiver Prior Authorization Process

Purpose: A waiver prior authorization is required when costs of a certain service under a Home and Community Based Services (HCBS) waiver are in excess of the median amount for payments as determined by the Department of Human Services (DHS). Medical Services reviews prior authorizations for members who are on one of the waiver programs:

- Physical Disability Waiver (PD)
- Brain Injury Waiver (BI)
- Health and Disability Waiver (H&D)
- AIDS/HIV Waiver
- Elderly Waiver (EW)
- Intellectual Disability Waiver (ID)
- Children's Mental Health Waiver (CMH)

Medical necessity will be determined by the review coordinator (RC) and means that the service is:

- Consistent with the diagnosis and treatment of the member's condition;
- Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- The least costly type of service that can reasonably meet the medical needs of the member; and in accordance with the standards of good medical practice.
- Consistent with Iowa Administrative Code (IAC) service definitions.

Identification of Roles:

Review Assistant (RA) – Assists in processing peer review information, appeal documentation, and with logging and assigning information in OnBase.

Review Coordinator (RC) – responds to PA requests, screens requests for completeness, reviews for compliance with policy, medical necessity and appropriate units and forwards to Peer Reviewer for review when needed.

Case Managers (CM) - complete the Assessment Tool with the member and other appropriate individuals, and develop a service care plan.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, and re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Peer Reviewer (PR) –reviews member cases and makes a recommendation based on medical and/or vocational records and additional documentation provided.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards:

- Initial prior authorization reviews will be completed for 100 percent of the members within two business days.
- Subsequent service reviews will be completed for 100 percent of the members within five business days.

Path of Business Procedure:

Step 1: The Certificate of Medical Necessity form will be completed by a case manager then submitted and/or faxed to Medical Services at 515-725-1388. The case manager (CM) will submit the necessary supporting documentation along with the request.
Step 2: Medical Services review staff may be reached by telephone or facsimile during regular business hours of 8:00 a.m. to 4:30 p.m., Monday through Friday with the exception of state holidays at the Iowa Medicaid Enterprise facility.
Step 3: The review coordinator (RC) will accept and process requests for initial and subsequent service reviews for waiver services. Faxed and uploaded requests are stored in the OnBase system. It is the goal of Medical Services to provide timely responsive information as requested by providers and members.

a. Initial reviews are completed within two business days and subsequent service reviews are completed within five business days of the request.
b. All reviews are performed on an individual basis to assure that services for the member are medically necessary.

Step 4: A comprehensive review of submitted documentation is analyzed and reviewed against the service criteria. Service criteria are located in MedSrv on dhsime\Criteria\All Programs Criteria. Review of Home or Vehicle Modifications, Assistive Devices, and Environmental Modification for purchases costing less than $50.00 will go through a modified prior authorization process effective July 25, 2011, per DHS Informational Letter 1035. The RC is able to approve when the Certificate of Medical Necessity is submitted and completed correctly and the item is correctly coded in the member's service plan.
Step 5: When the RC is unable to determine appropriate request for services, based on the information provided, the case manager is contacted by telephone and/or email in an attempt to gather all available information regarding the member's status prior to taking the case to physician review (PR).
Step 6: Any RC who is requesting additional information will only request what is needed to complete the review.
Step 7: The RC will review submitted documentation to ensure that the request is complete.
Step 8: The RA and/or RC will complete a request for additional information if needed.

a. The RAs do not make clinical decisions or complete clinical interpretation of information.

Step 9: Only PRs make denial or modified decisions. Peer reviewers include licensed health care professions in the same category as the attending provider. Denials made by the CAMD will be reviewed by the MMD or other licensed physician. Denial decisions are entered into ISIS by the RC.
Step 10: Notice of the availability of the peer-to-peer conversation is included on the Iowa Medicaid Enterprise (IME) website http://dhs.iowa.gov/ime/providers/rights-and-responsibilities. Reference the MED Administrative Functions Peer-to-Peer Conversations for details on this procedure.

a. Click on Providers
b. Important Provider Announcements
c. Peer-to-Peer Conversation

Step 11: The manager will arrange for the peer-to-peer conversation within one business day of the request unless there are extenuating circumstances outside of Medical Services' control.

Step 12: Urgent requests for prior authorization of services will be reviewed and a decision rendered and communicated within 72 hours from receipt of the request. See Administrative Functions – Urgent Reviews.

Forms/Reports:

Certificate of Medical Necessity for
Home and Vehicle Modification
Use this form as your cover page. Fax to Medical Services Waiver Prior Authorization 515-725-1388.
(Please print or type clearly – accuracy is important)

Section A								
1. Member Name (Last) (First) (Initial)				2. Case Manager Name				
3. Medicaid SID #	4. Date of Birth			5. Service Plan Dates Covered by Request				
				From			To	
				M	D	Ye	M	D
6. Name of Item Requested:								
7. Type of Review Being Requested: ☐ Initial ☐ Continued Stay Review (CSR) ☐ Revised form ☐ Re-review				*Remember to attach all documentation.* 8. Documentation attached? ☐ Yes ☐ No **(see Section D)** 9. Number of pages including this one:				

Section B Answer ALL Questions 1 through 13 for Home and Vehicle Modification	
☐ Yes ☐ No	1. Have other funding sources been tried? Outline in Section C. ☐ Community services fund ☐ Family ☐ Other ☐ Charitable organizations ☐ State plan durable medical equipment
☐ Yes ☐ No	2. Is this modification covered by other funding sources? Outline in Section C.
☐ Yes ☐ No	3. Is this an existing structure? If yes, provide detailed information in Section C.
☐ Yes ☐ No	4. If this is an existing structure, can it be repaired? Describe in Section C.
☐ Yes ☐ No	5. Is this modification for the sole benefit of the member? Describe benefit to member in Section C.
☐ Yes ☐ No	6. Are any of the contractors related to the member? If yes, provide relationship in Section C.
☐ Yes ☐ No	7. Will this modification increase or maintain the independence of the member? If yes, outline in Section C.
☐ Yes ☐ No	8. Does this modification address a health, safety, or welfare issue for this member? Outline in Section C.
☐ Yes ☐ No	9. Does the service plan indentify the need for requested modification?
☐ Yes ☐ No	10. Will the case manager obtain assurance of liability and workers compensation coverage from contractor?
☐ Yes ☐ No	11. To the best of case manager's knowledge, are the contractors submitted for review reputable?

☐ Yes ☐ No	12. If vehicle modification, is the primary vehicle used by the member? Outline details in Section C.
☐ Yes ☐ No	13. Does the member or member's family ☐ Own housing ☐ Live in provider-owned home ☐ Rent ☐ Live in HUD

Section C Narrative Description Justification Request	
Provide specific information and use additional sheet if necessary. Provide the cost of items that are $50 or under.	
IMPORTANT NOTE: In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.	Requesting Case Manager Signature of TCM/CM/SW Date

Section D Include ALL of the Following Documentation

- Comprehensive functional assessment
- Case manager or social worker service plan
- Denial for state plan durable medical equipment, if applicable
- If existing item, need repair versus replacement cost estimate
- Documented description of the item that includes the medical, remedial, or safety benefit to the member
- Three independent itemized estimates (if over $50)

470-5050 (8/11)

Certificate of Medical Necessity for Consumer-Directed Attendant Care

Use this form as your cover page. Fax to Medical Services Waiver Prior Authorization 515-725-1388.

(Please print or type clearly – accuracy is important)

Section A

1. Member Name (Last) (First) (Initial)			2. Case Manager Name					
3. Medicaid SID #	4. Date of Birth		5. Service Plan Dates Covered by Request					
			From			To		
			M	Da	Ye	M	Da	
6. Name of Item Requested:								
7. Type of Review Being Requested: ☐ Initial ☐ Continued Stay Review (CSR) ☐ Revised form ☐ Re-review			*Remember to attach all documentation.* 8. Documentation attached? ☐ Yes ☐ No **(see Section D)** 9. Number of pages including this one:					

Section B Answer ALL Questions 1 through 9 for CDAC Services

☐ Yes ☐ No	1. Besides the CDAC provider is there another person who will assist this member with ADL or IADL cares? Outline details in Section C and submit schedule.

☐ Yes ☐ No	2. Does this member live with the CDAC provider? Outline relationship and provide total number of people in household in Section C.
☐ Yes ☐ No	3. Do one or more primary caregivers work outside the home? If yes, list hours worked by caregivers in Section C.
☐ Yes ☐ No	4. Are CDAC hours increased in this service plan? Outline rationale in Section C.
☐ Yes ☐ No	5. Does this member have an identified health, safety, or welfare risk? Outline in Section C.
☐ Yes ☐ No	6. Does this member have an acute condition with expectation to improve in one year? Outline in Section C.
☐ Yes ☐ No	7. Is the CDAC provider assigned to perform skilled services? Provide name and contact information of agency oversight in Section C.
☐ Yes ☐ No	8. Is this member employed? Is the member receiving CDAC services during hours of employment? Outline in Section C.
☐ Yes ☐ No	9. Does this member share residence with another recipient of waiver CDAC services? Does the CDAC provider provide services to more than one member in the household? Are there any services occurring at the same time? Outline in Section C.

Section C Narrative Description Justification Request	
Provide specific information and use additional sheet if necessary.	
IMPORTANT NOTE: In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.	Requesting Case Manager Signature of TCM/CM/SW Date

Section D Include ALL of the Following Documentation	
• Comprehensive functional assessment • Case manager or social worker service plan • Home health agency plan of care, if applicable	• List all natural, waiver, and non-waiver support services • Supported community living providers service plan, if applicable • HCBS consumer-directed attendant care agreement

470-5048 (8/11)

Certificate of Medical Necessity for Environmental Modification

Use this form as your cover page. Fax to Medical Services Waiver Prior Authorization 515-725-1388.

(Please print or type clearly – accuracy is important)

Section A									
1. Member Name (Last) (First) (Initial)				2. Case Manager Name					
3. Medicaid SID #	4. Date of Birth			5. Service Plan Dates Covered by Request					
				From			To		
				M	D	Ye	M	D	
6. Name of Item Requested:									
7. Type of Review Being Requested: ☐ Initial ☐ Continued Stay Review (CSR) ☐ Revised form ☐ Re-review				*Remember to attach all documentation.* 8. Documentation attached? ☐ Yes ☐ No **(see Section D)** 9. Number of pages including this one:					

Section B Answer ALL Questions 1 through 13 for Environmental Modification	
☐ Yes ☐ No	1. Have other funding sources been tried? Outline in Section C. ☐ Community services fund ☐ Family ☐ Other ☐ Charitable organizations ☐ State plan durable medical equipment
☐ Yes ☐ No	2. Is this device covered by other funding sources? Outline in Section C.
☐ Yes ☐ No	3. Is this an existing structure? If yes, provide detailed information in Section C.
☐ Yes ☐ No	4. If this is an existing structure, can it be repaired? Describe in Section C.
☐ Yes ☐ No	5. Is this modification for the sole benefit of the member? Describe benefit to member in Section C.
☐ Yes ☐ No	6. Are any of the contractors related to the member? If yes, provide relationship in Section C.
☐ Yes ☐ No	7. Will this modification increase or maintain the independence of the member? If yes, outline in Section C.
☐ Yes ☐ No	8. Does this modification address a health, safety, or welfare issue for this member? Outline in Section C.
☐ Yes ☐ No	9. Does the service plan identify the need for requested modification?
☐ Yes ☐ No	10. Will the case manager obtain assurance of liability and workers compensation coverage from contractor?
☐ Yes ☐ No	11. To the best of my knowledge, the contractors submitted for review are reputable?
☐ Yes ☐ No	12. Is there documentation that a mental health professional has recommended this modification? Outline details in Section C.
	13. Does the member or member's family ☐ Own ☐ Live in provider-owned home ☐ Rent ☐ Live in HUD

	housing

Section C Narrative Description Justification Request	
Provide specific information and use additional sheet if necessary. Provide the cost of items that are $50 or under.	
IMPORTANT NOTE: In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.	Requesting Case Manager Signature of TCM/CM/SW Date

Section D Include ALL of the Following Documentation

- Comprehensive functional assessment
- Case manager or social worker service plan
- Three independent itemized estimates (if over $50)
- Mental health professional recommendation
- Denial for state plan durable medical equipment, if applicable
- If existing item, need repair versus replacement cost estimate
- Documented description of the item that includes the medical, remedial, or safety benefit to the member

470-5049 (8/11)

Certificate of Medical Necessity for Prevocational Services

Use this form as your cover page. Fax to Medical Services Waiver Prior Authorization 515-725-1388.

(Please print or type clearly – accuracy is important)

Section A								
1. Member Name (Last) (First) (Initial)				2. Case Manager Name				
3. Medicaid SID #	4. Date of Birth			5. Service Plan Dates Covered by Request				
				From			To	
				M	Da	Ye	M	Da
6. Name of Item Requested:								
7. Type of Review Being Requested: ☐ Initial ☐ Continued Stay Review (CSR) ☐ Revised form ☐ Re-review				*Remember to attach all documentation.* 8. Documentation attached? ☐ Yes ☐ No **(see Section D)** 9. Number of pages including this one:				

Section B Answer ALL Questions 1 through 9 for Prevocational Services	
☐ Yes ☐ No	1. Is this member currently receiving prevocational services? If yes, outline history on program in Section C.
☐ Yes ☐ No	2. Has this member ever received sheltered workshop, enclave, or supported employment? If yes, outline history in Section C.
☐ Yes ☐ No	3. Has this member volunteered or had competitive employment? If yes, outline history in Section C.
☐ Yes ☐ No	4. What are the long-term employment goals? Outline in Section C.
☐ Yes ☐ No	5. Have goals been updated or changed in the last 12 months? If yes, outline in Section C.
☐ Yes ☐ No	6. Does the prevocational service plan indicate that the services teach job-ready skills? List the services performed in Section C.
☐ Yes ☐ No	7. Has this member been denied from the Vocational Rehabilitation Division? If yes, enclose denial documentation.
☐ Yes ☐ No	8. If enrolled in school, are programs available through the school that provide the same types of skill development? If yes, outline in Section C.
☐ Yes ☐ No	9. Has progress been made to justify prevocational services? If yes, outline in Section C.

Section C Narrative Description
Justification for request. Provide specific information and use additional sheet if necessary.

IMPORTANT NOTE: In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.	Requesting Case Manager Signature of TCM/CM/SW Date

Section D Include ALL of the Following Documentation
• Comprehensive functional assessment • Case management or social worker service plan • Denial documentation from Division of Vocational Rehabilitation • Supported employment readiness assessment (prevocational assessment of needs) • Time study reports for three years for initial reviews or past 12 months for a CSR. If less than requested duration, include all time in prevocational services • Prevocational goals, objectives, and results for three years for initial reviews or past 12 months for a CSR. If less that requested duration, include all prevocational services • Prevocational provider's service plan • Individualized Education Program, if enrolled in school and applicable

470-5051 (8/11)

Certificate of Medical Necessity for
Waiver Assistive Devices

Use this form as your cover page. Fax to Medical Services Waiver Prior Authorization 515-725-1388.

(Please print or type clearly – accuracy is important)

Section A								
1. Member Name (Last) (First) (Initial)			2. Case Manager Name					
3. Medicaid SID #	4. Date of Birth		5. Service Plan Dates Covered by Request					
			From			To		
			M	Da	Ye	M	Da	
6. Name of Item Requested:								
7. Type of Review Being Requested: ☐ Initial ☐ Continued Stay Review (CSR) ☐ Revised form ☐ Re-review			*Remember to attach all documentation.* 8. Documentation attached? ☐ Yes ☐ No **(see Section D)** 9. Number of pages including this one:					

Section B Answer ALL Questions 1 through 6 for Assistive Devices	
☐ Yes ☐ No	1. Have other funding sources been tried? Outline in Section C. ☐ Community services fund ☐ Family ☐ Other ☐ Charitable organizations ☐ State plan durable medical equipment
☐ Yes ☐ No	2. Is this device covered by other funding sources? Outline in Section C.
☐ Yes ☐ No	3. Will the device increase or maintain independence of the member? Outline in Section C.
☐ Yes ☐ No	4. Does the device address a health, safety, or welfare issue for this member? Outline in Section C.
☐ Yes ☐ No	5. Does the service plan identify the need for the requested device?
☐ Yes ☐ No	6. Does this device address an ADL or IADL need? Outline in Section C.

Section C Narrative Description Justifying Request	
Provide specific information and use additional sheet if necessary. Provide the cost of items that are $50 or under.	
IMPORTANT NOTE: In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.	Requesting Case Manager Signature of TCM/CM/SW Date

Section D Include ALL of the Following Documentation
• Comprehensive functional assessment • Case manager or social worker service plan • Three independent itemized estimates (if over $50) • Documented description of the item that includes the direct medical, remedial, or safety benefit to the member • Denial from state plan durable medical equipment, if applicable

470-5047 (8/11)

Re: ,
Last four digits of Medicaid ID #
Month and date of birth (omitting year for privacy/confidentiality) *
Waiver Prior Auth reference number:

Dear :

Medical Services has received a request for prior authorization for waiver services on the above member. In order to process the request for prior authorization, additional information is required. The items below are necessary to complete this request:

☐ Case Management comprehensive assessment, most recent.
☐ List of all natural, waiver and non-waiver service providers including: description of services performed, frequency with name and contact information.
☐ Case Manager comprehensive service Plan.
☐ Schedule of a representative week for service delivery, frequency and time allowed when receiving multiple personal care service providers.
☐ Documentation/research to support item requested. Documentation must be from source other than provider of item requested.
☐ Additional documentation is needed as follows:

.Please do not send original documents, send copies only.

In order to expedite the review, please attach the above-checked items and return by to:

Fax to 515-725-1388 (preferred)
OR
Mail to:
Medical Services Waiver PA Team
Iowa Medicaid Enterprise
PO Box 36478
Des Moines, IA 50315

Thank you for your prompt response. Should you have any questions regarding this request, please contact toll free at 800-383-1173 or (515) 256-4623 in the Des Moines area.

Sincerely,

Name, credentials
Title
Iowa Medicaid Enterprise
Medical Services – Waiver Team

AUTHORITY FOR REQUEST AND RELEASE OF RECORDS FOR

MEDICAID REVIEW

Under Title 45 of the Code of Federal Regulations (CFR) 164.506, a covered entity may disclose or release Protected Health Information without the individual's authorization for treatment, payment, and health care operation activities. According to 45 CFR 164.501, "health care operations" include conducting or arranging for medical review, legal service, and auditing functions including fraud and abuse detection and compliance programs.

Title XIX of the Social Security Act, Sections 1902 and 1903, and regulations found in 42 CFR 456, stipulate that utilization review activities are required to ensure that services rendered are necessary and of optimum quality and quantity. Federal regulations found in 42 CFR 455 require the State to have the ability to identify and refer cases of suspected fraud and/or abuse in the Iowa Medicaid program for investigation and/or prosecution. Utilization review safeguards against unnecessary care and services and ensures that payments are appropriate according to the coverage policies established by the Department of Human Services Iowa Administrative Code 441—79.4. The areas of review include, but are not limited to, the areas listed below.

- Standards of care
- Medical necessity
- Documentation

The utilization review process assists Medicaid policy staff in making important policy decisions, such as identifying areas of policy that require clarification or change. It is an invaluable tool in shaping policy guidelines and ensuring that services are provided in an efficient and effective manner.

Date

CDAC provider name
street address
city, state zip code

RE: Member's first initial, last name State ID XXXX - last four digits of number

The CDAC services for Member's first initial, last name are being evaluated. As the provider for Member's first initial, last name, please fax your CDAC daily service records and transportation logs for time period to 515-725-1388.

If you would prefer to mail copies of your notes, please send them to:

IME Medical Services Unit
Attn: Waiver Prior Authorization
100 Army Post Road
Des Moines, Iowa 50315

Do not mail your originals.

According to Iowa Code 441-79.4(2), any Medicaid provider may be reviewed at any time by the department.

Thank you for your help with this review. Please mail or fax your notes by Date .

If you have any questions, please contact RC's name at 1-800-383-1173 extension number or 515-974-number .

Sincerely,

Name, Credentials
Title
Medical Services
Iowa Medicaid Enterprise

A copy of this letter must be included as the first page of your documentation.

Date

Agency name
street address
city, state zip code

RE: Member's first initial, last name State ID # XXXX - Last four digits of number

The Prevocational services for Member's first initial, last name are being evaluated. As the provider for Member's first initial, last name, please fax your Prevocational records to 515-725-1388. Include the following available documentation:

- Places of employment and work history with dates (include all paid work, supported employment, Enclave, job coaching, sheltered workshop, unpaid or volunteer work, etc) and funding source (utilization of attached form optional);
- annual prevoc progress reports since 20XX;
- progress chart (final yearly report/summary) since 20XX;
- service notes for the final month of each annual plan; and
- service notes for the last three months of prevoc services.

If you would prefer to mail copies of your notes, please send them to:

IME Medical Services Unit
Attn: Waiver Prior Authorization
100 Army Post Road
Des Moines, Iowa 50315

Do not mail your originals.

According to Iowa Code 441-79.4(2), any Medicaid provider may be reviewed at any time by the department.

Thank you for your help with this review. Please mail or fax your notes by Date.

If you have any questions, please contact 515-974-XXXX or 1-800-383-1173.

Sincerely,

Name, Credentials

Title

Medical Services
Iowa Medicaid Enterprise

A copy of this letter must be included as the first page of your documentation.

Work History Summary

Name: State ID:
Provide places of employment and work history with dates of the member (include all paid work, supported employment, Enclave, job coaching, sheltered workshop, unpaid or volunteer work, etc) and funding source.

Place of Employment	**Dates of Employment**	**Job Title/** **Primary Duties**	**Program/Service name-** sheltered workshop, supported employment, Enclave, job coaching, prevoc, etc.	**Funding source**- competitive employment, unpaid/volunteer, Voc Rehab, Medicaid, County, etc.	**Hourly wage-** Please include final hourly wage received at each employer

**** Some work may be piece rated- please take the member's most recent paycheck and divide the gross earnings by the hours of active work within that pay period to obtain an hourly wage.**

Interfaces:
ISIS
OnBase

RFP Reference:
6.2.4.2

Attachments:
N/A

MED – Waiver Prior Authorization Lack of Information

Purpose: To obtain any additional information from the case manager that was not provided to determine outcome.

Identification of Roles:

Review Coordinator (RC) – when needed will request necessary information.

Review Assistant (RA) – will forward to RC any additional information that is faxed in.

Case Managers (CM) – will provide the additional information requested.

Performance Standards:

- Initial prior authorization reviews will be completed for 100 percent of the members within two business days.
- Subsequent service reviews will be completed for 100 percent of the members within five business days.

Path of Business Procedure:

Step 1: If the RC is unable to determine the review outcome due to lack of information the RC will contact the case manager by telephone or email to request additional information about the member, to better understand the services provided. This may include the service plan, assessment, progress on goals, Consumer Directed Attendant Care (CDAC) agreement and/or other relevant documentation.
Step 2: If the case manager provides additional information, a clarification can be taken over the telephone by the RC or the information can be faxed to medical services at 515-725-1388. Only information that is necessary to approve the service may be requested.
Step 3: The RC will not require any additional information that is not needed for prior authorization.
Step 4: If the RC does not receive additional information within ten business days, the RC may complete a technical denial or proceed with PR, for CDAC services only, with the information available.

Forms/Reports:

Please use this letter as the cover page with your submission.

Re: ,
Last four digits of Medicaid ID #
Month and date of birth (omitting year for privacy/confidentiality) *
Waiver Prior Auth reference number:

Dear :

Medical Services has received a request for prior authorization for waiver services on the above member. In order to process the request for prior authorization, additional information is required. The items below are necessary to complete this request:

☐ Case Management comprehensive assessment, most recent.
☐ List of all natural, waiver and non-waiver service providers including: description of services performed, frequency with name and contact information.
☐ Case Manager comprehensive service Plan.
☐ Schedule of a representative week for service delivery, frequency and time allowed when receiving multiple personal care service providers.
☐ Documentation/research to support item requested. Documentation must be from source other than provider of item requested.
☐ Additional documentation is needed as follows:

.Please do not send original documents, send copies only.

In order to expedite the review, please attach the above-checked items and return by date to:

Fax to 515-725-1388 (preferred)
OR
Mail to:
Medical Services Waiver PA Team
Iowa Medicaid Enterprise
PO Box 36478
Des Moines, IA 50315

Thank you for your prompt response. Should you have any questions regarding this request, please contact toll free at 800-383-1173 or (515) 256-4623 in the Des Moines area.

Sincerely,

Name, Credentials
Title
Iowa Medicaid Enterprise
Medical Services – Waiver Team

AUTHORITY FOR REQUEST AND RELEASE OF RECORDS FOR

MEDICAID REVIEW

Under Title 45 of the Code of Federal Regulations (CFR) 164.506, a covered entity may disclose or release Protected Health Information without the individual's authorization for treatment, payment, and health care operation activities. According to 45 CFR 164.501, "health care operations" include conducting or arranging for medical review, legal service, and auditing functions including fraud and abuse detection and compliance programs.

Title XIX of the Social Security Act, Sections 1902 and 1903, and regulations found in 42 CFR 456, stipulate that utilization review activities are required to ensure that services rendered are necessary and of optimum quality and quantity. Federal regulations found in 42 CFR 455 require the State to have the ability to identify and refer cases of suspected fraud and/or abuse in the Iowa Medicaid program for investigation and/or prosecution. Utilization review safeguards against unnecessary care and services and ensures that payments are appropriate according to the coverage policies established by the Department of Human Services Iowa Administrative Code 441—79.4. The areas of review include, but are not limited to, the areas listed below.

- Standards of care
- Medical necessity
- Documentation

The utilization review process assists Medicaid policy staff in making important policy decisions, such as identifying areas of policy that require clarification or change. It is an invaluable tool in shaping policy guidelines and ensuring that services are provided in an efficient and effective manner.

RFP Reference:

6.2.4.2

Interfaces:

N/A

Attachments:

N/A

MED – Waiver Prior Authorization Not Met

Purpose: When the RC is unable to approve a request for services the RC will send the case to peer review (PR).

Identification of Roles:

Review Coordinator (RC) – requests PR review for prior authorization.

Review Assistant (RA) – forward request to peer review and follow up as needed.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, and re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Peer Reviewer (PR) – reviewins medical or vocational records for a variety of reasons.

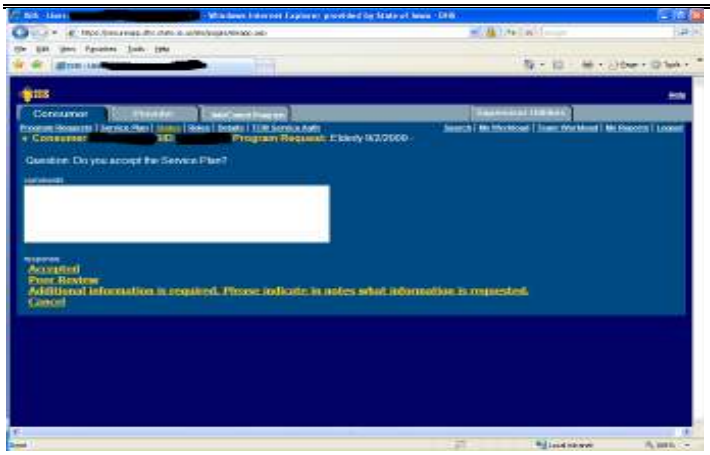
Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards:

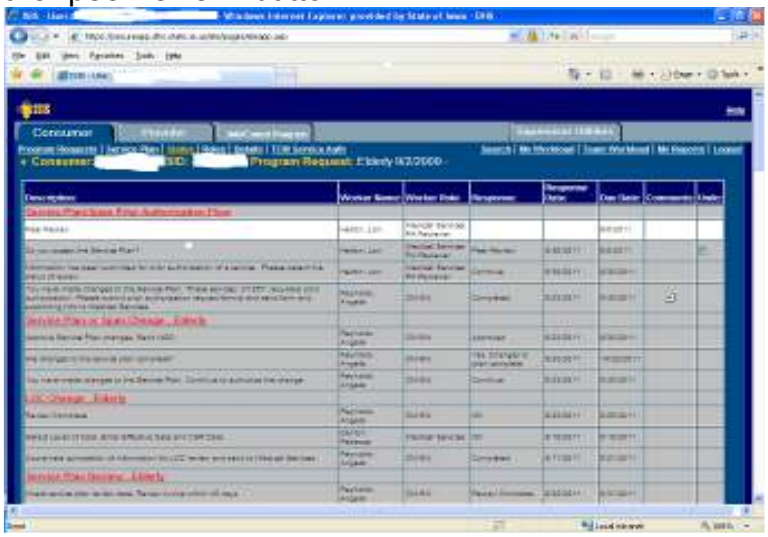
- Initial prior authorization reviews will be completed for 100 percent of the members within two business days.
- Subsequent service reviews will be completed for 100 percent of the members within five business days.

Path of Business Procedure:

Step 1: The RC will open MD router form through OnBase.
Step 2: The RC will fill out form as needed to reflect member's review and then fill in the appropriate information on the request.
Step 3: The RC will save form in OnBase and fill out appropriate key words.
a. This will attach the MD router request to the LOC request or the create letter task will attach MD Router.
Step 4: The RC will then click send to consultant in the tasks bar.
a. The document then will go to the PR queue.
Step 5: The MMD and/or CAMD may elect to have any request forwarded to an outside PR.
a. If consultant is outside of office, the RA will confirm by phone that consultant is available and send review packet by fax, courier, email or overnight delivery.
b. If a request is not returned from the PR within two business days, the document will go to the Follow-up with Consultant queue.
Step 6: The RA will contact PR regarding the status of the review. The PAs/RAs do not make clinical decisions or complete clinical interpretation of information.



Step 7: The RC will pend the case in ISIS until the PR decision is received by pressing the "peer review" button.



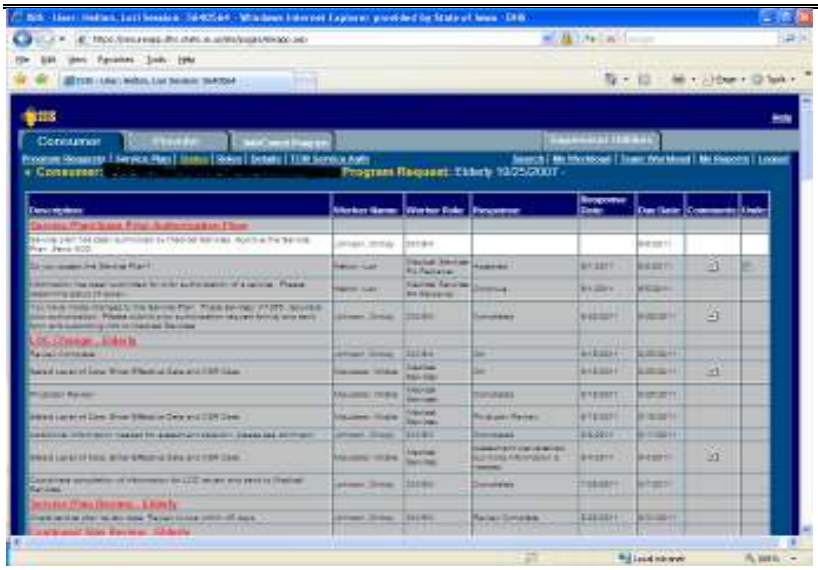
Step 8: The RC will select PR when answering ISIS milestone on the status page for the member.

Step 9: If the PR is external, the RA will log the number of minutes spent by the PR for the review on keywords tasks. This is not needed if the CAMD or MMD is used for the PR review.

Step 10: When the PR is completed, the document is returned through the WPA workflow in Onbase.

Step 11: The RC will then find the document in the Back from Consultant queue.

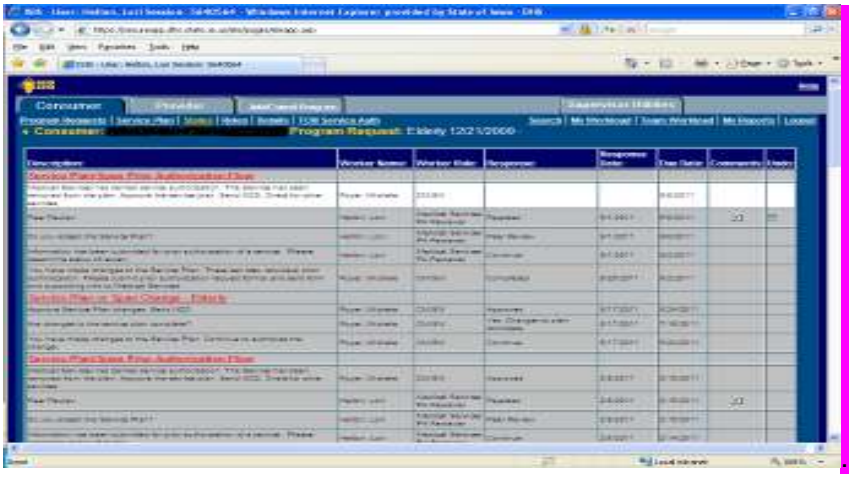
Step 12: The RC will enter the authorization decision in ISIS and complete OnBase approval, modification or denial.



Step 13: If the PR results in approval, the RC will follow the procedures outlined for decision met.

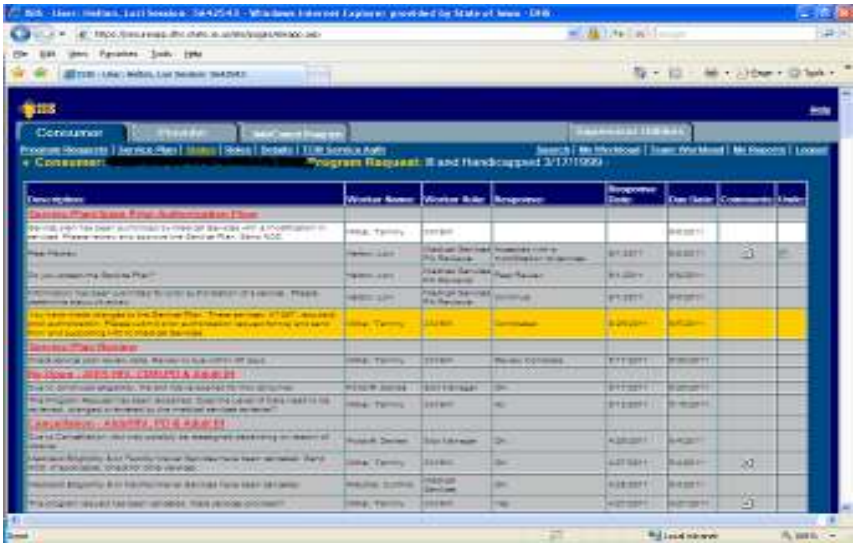
Step14: If the PR results in denial determination, the RC will document the denial in ISIS. All denials require a principle reason and clinical rationale of why the member was denied in the comments section for the milestone.

Step 15: The RC will choose denied in ISIS.



Step 16: The member is notified of the denial determination from the NOD generated from the ISIS system.

Step 17: If the PR results in approved with modifications, the RC will document the modification in ISIS. All approved with modifications require a principle reason and clinical rationale of why the member received a modification in the comments section for the milestone.



Step 18: The RC will choose accepted with modifications in ISIS.

Step 19: The RC will send approved CDAC units to the case manager so the provider can alter the CDAC agreement to match according to the DHS Informational Letter 1093.

Forms/Reports:

Medical Services - Request for Medical Director Review
Route all requests for Medical Director review to Medical Services

Waiver Prior Authorization

Person requesting review: _____ Ext: _____

Date:

Review Type:
PA Number:
Member Name:
Member ID:

Please review for medical necessity for (service name):
Case Summary: (explain reason for Medical Director review - include known facts, concerns, etc.)

_____

Medical Director rationale for decision:

☐Concern Identified ☐No Concern Identified ☐Approve ☐Deny

☐ Modify Request to (include unit and rationale for modification): _____

Please indicate amount of time spent reviewing this case: _____

External consultants utilized: ☐Yes (identify below) ☐No

External consultant(s): _____

Medical Director Signature: _____ Date: _____

MDRouter/WPA/102010

RFP Reference:
6.2.4.2

Interfaces:
N/A

Attachments:
N/A

MED – Waiver Prior Authorization Appeal Process

Purpose: A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the notice of action letter by contacting the local DHS office, by writing a letter to DHS Appeals Section or by filing on line at http://dhs.iowa.gov/appeals/appeal-a-dhs-decision . The notice of action letter contains instruction on how to request an appeal. Medical Services provides testimony for assigned appeal hearings. Please reference Administrative Functions Procedures MED-Policy Support Appeals.

Identification of Roles:
Review Coordinator (RC) – Compiles appeal packet and information for testimony in appeal hearings.

Review Assistant (RA) – Disseminates packets and coordinates hearing coverage.

Manager – Receives appeal requests from DHS, completes, proofs appeal packets and provides testimony.

Lead Review Coordinator (RC) – Reviews appeal summary and exhibits for accuracy and may provide testimony or write appeal summaries.

Medicaid Medical Director (MMD) – Provides testimony for appeals.

Clinical Assistant to the Medicaid Medical Director (CAMD) - Provides testimony for appeals.

Administrative Law Judge (ALJ) - Presides over the appeal.

Performance Standards:

Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: The RA receives appeal information from the Project Assistant (PA).
Step 2: The RA records appeal activity on appeal spreadsheet located on Medsrv_:\WPA Appeals Tracking and Forms\Appeal Log by entering the following:

a. Appeal Number
b. Member SID
c. Member Name
d. Waiver type
e. Service appealed
f. Date Received
g. RC assigned
h. Prehearing date and time
i. Member's benefits continued
j. Interpreter requested
k. Date proofed packets mailed
l. Appeal hearing date and time
m. ALJ assigned
n. Decision
o. Directors decision and date
p. Comments

Step 3: The RC, Lead RC or Manager writes the case summary using standard templates.
Step 4: If needed, the RC will request additional information from member or other appropriate source.
Step 5: If RC's review of the case or additional information indicates that the adverse decision can be reversed:

a. The RC will proceed with obtaining necessary approval of services i.e., approving the prior authorization and approving services in ISIS.
b. The RC uses standard template addressed to Administrative Law Judge (ALJ) requesting dismissal of appeal.
c. Upon manager approval, the RA or RC sends letter to member, ALJ, Income Maintenance (IM) Worker, and other involved party, if applicable.
d. The letter is sent by inter-office mail to Department of Inspection and Appeals (DIA), ALJ, and emailed to IM Worker and/or CM.

Step 6: If the RC decision is upheld, the RC and/or RA proceeds with completion of appeal packet.
Step 7: Appeal packet includes appeal memorandum, information regarding member that was used by Medical Services in making decision, Iowa Administrative Code (IAC), program criteria, and other relevant information. Packets will be individualized based on the reason for appeal.
Step 8: The RA or RC forwards completed packet to manager for review.
Step 9: After review the manager forwards packet to RA for dissemination to member, ALJ, IMW, and other involved party, if applicable.
Step 10: Packets are sent by inter-office mail to DIA, ALJ, and DHS policy staff. Packets for DIA should have DIA envelope attached directing appeal to head ALJ or her representative. Appeal summaries may be emailed to IM Workers.
Step11: The RA receives scheduled hearing notice from DHS share coordinator.
Step 12: The RA logs it on the spreadsheet and distributes to representative(s) of team.
Step 13: The RA records appeal activity on appeal spreadsheet by entering appeal date.

Step 14: The RA schedules conference room for the hearing if needed and sends notices in Outlook and/or phone to attendees.
Step 15: Testimony provided by manager may be provided at the Manager's desk and room scheduling may not be needed.
Step 16: The RC, manager and/or peer reviewer providing testimony calls in for telephonic appeal hearing.
Step 17: The appeal hearing is convened and conducted by the ALJ.
Step 18: Following the appeal, the RA receives appeal decision.
Step 19: The RA distributes the decision to representative(s) of team by email.
Step 20: The RA or Lead RC records appeal activity on appeal spreadsheet by entering determination and notes, if applicable.
Step 21: If decision is affirmed no further action is needed.
Step 22: If decision is reversed, the manager reviews the decision to determine if a director review is warranted.
Step 23: The manager may consult with respective DHS policy specialist. If the decision is to pursue a director review, the manager composes a memo stating the request for review and submits it to the designated policy specialist representative on the appeals committee.
Step 24: If the decision is not to pursue a director review, the RC awaits the final decision and then proceeds with completing approval of services consistent with the court order by approving services in ISIS.
Step 25: If decision is reversed the RC removes calculated cost savings from Onbase.

Forms/Reports:

TO: Iowa Department of Inspections and Appeals
Division of Administrative Hearings

ATTENTION: ALJ's name, Administrative Law Judge

FROM: Division of Medical Services, Vicki Vermie

DATE: date

SUBJECT: Appeal Summary for members name,

Appeal Number MED number

On date received, Iowa Medicaid Enterprise, Medical Services received a request for prior approval of Consumer Directed Attendant Care (CDAC) service for members name. The prior authorization request is necessary to approve the service level request as per Senate File 2088 and Informational Letter 928.

The information provided by CM name, Case Manager, identified members name as a age year-old gender. The case manager requested number units of CDAC service. The information that was provided for review on the case management assessment indicated that members name is independent with list areas member is independent in. The areas on the assessment which note members name requires assistance include: list areas the member needs assistance with as listed in documentation.

The notes indicate list any additional notes pertinent to the case.

The level of care form indicates that this member needs assistance with list areas the Long Term Care (LTC) form states the member needs assistance .

The information submitted for members name and reviewed by Medical Services did not warrant the requested units of service. The review coordinator found that the member has a diagnosis of list diagnoses. After review of the case manager's assessment, the CDAC agreement, and based on the member's functional abilities taken from the case manager assessment, there is a decrease in requested time for list areas where the units were decreased.

The case was forwarded to a peer reviewer for a medical necessity determination on date sent to peer review. The peer reviewer reviews all of the information that was submitted and relies on medical expertise and judgment to determine medical necessity. The peer reviewer evaluated this case in accordance with Iowa Administrative Code 79.9(2) which states the services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.
b. Be in accordance with standards of good medical practice.
c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
d. Be the least costly type of service which would reasonably meet the medical need of the patient.

The peer reviewer also takes into consideration the Iowa Administrative Code governing the administration of the service:

enter the IAC

The peer reviewer did not approve the prior authorization request of number units for members name based on the following rationale:

- Peer review rationale The CDAC service is designed to help a member with self care task which the member would perform on their own, if they were able. It would not be medically necessary to provide services to the member which the member was assessed to be able to complete on his own. Reason and rationale specific to review

date**:** The Case Manager was notified of Medical Service's determination via ISIS.

date**:** Correspondence was received from member or representative name requesting an appeal of the adverse decision. Medical Services reviewed the information included in the appeal packet received to determine if new medical information was supplied. If the member or representative supplies additional information, then a review is completed on the current case. No additional information was supplied in this packet for review; therefore, no formal review was done at this time. Or additional information was reviewed and did not warrant a change in decision.

The Department maintains the original decision was correct.
Thank you for your consideration in this matter. If you have any questions, please contact me at 515-XXX-XXXX.

Sincerely,

Name, credentialsTitle
Medical Services, Iowa Medicaid Enterprise

Enclosures:
Exhibit A: Appeal Memorandum

Exhibit B: Consumer Directed Attendant Care Scoring Guide
Exhibit C: Documentation
Exhibit D: Iowa Administrative Rule
Exhibit E: Peer Review Credentials

cc: Name

street address
city, state zip code

CM name
Agency name
street address
city, state zip code

TO: Iowa Department of Inspections and Appeals
Division of Administrative Hearings

ATTENTION: ALJ's name, Administrative Law Judge

FROM: Division of Medical Services, Name, Credentials

DATE: Date

SUBJECT: Appeal Summary for members name,
Appeal Number MED number

On date request was received, Iowa Medicaid Enterprise, Medical Services received a request for prior approval of waiver service for members name
The information provided by CM name, title, identified members name as a age year-old gender. The case manager requested a waiver service. The information provided for review included list items available for review which is included in Exhibit C. The case plan and documentation describes specific to review , and notes several items of interest which are as follows: specific to review.

The information submitted for members name and reviewed by Medical Services did not warrant the requested units of service. The request did not match what was in the Iowa Administrative Code concerning waiver service.

The case was forwarded to a peer reviewer for a medical necessity determination on date. The peer reviews all of the information that was submitted and relies on medical expertise and judgment to determine medical necessity. The peer reviewer evaluated this case in accordance with Iowa Administrative Code 79.9(2) which states the services covered by Medicaid shall:

e. Be consistent with the diagnosis and treatment of the patient's condition.
f. Be in accordance with standards of good medical practice.

g. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

h. Be the least costly type of service which would reasonably meet the medical need of the patient.

The peer reviewer also takes into consideration the Iowa Administrative Code governing the administration of the service:

enter the IAC

The peer reviewer did not approve the prior authorization request for a members name based on the following rationale:

- Peer review rationale

Medical Services maintains that the request for a waiver service does not meet the criteria for several reasons:

date**:** The Case Manager was notified of Medical Service's determination via ISIS.

date**:** Correspondence was received from member or representative name requesting an appeal of the denial determination. Medical services reviewed the information included in the appeal packet received to determine if new medical information was supplied. If the member or representative supplies additional information, then a review is completed on the current case. No additional information was supplied in this packet for review; therefore, no formal review was done at this time. Or additional information was reviewed and did not warrant a change in decision.

The Department maintains the original decision was correct.
Thank you for your consideration in this matter. If you have any questions, please contact me at 515-XXX-XXXX

Sincerely,

Name, credentials
Title
Medical Services, Iowa Medicaid Enterprise

Enclosures:
Exhibit A: Appeal Memorandum
Exhibit B: Iowa Administrative Rule
Exhibit C: Documentation
Exhibit D: Peer Review Credentials

cc: Name
street address
city, state zip code

CM name
Agency name
street address
city, state zip code

TO: Iowa Department of Inspections and Appeals
Division of Administrative Hearings

ATTENTION: ALJ's name, Administrative Law Judge

FROM: Division of Medical Services, Name, credentials

DATE: Date

SUBJECT: Appeal Summary for members name,
Appeal Number MED number

On date request was received, Iowa Medicaid Enterprise, Medical Services received a request for prior approval of Prevocational services for members name.

The information provided by CM name, title, identified members name as an age year-old gender. The case manager requested number units of Prevocational service. The Individualized Services Information System (ISIS) indicates this member has received prevocational services since start date of prevocational services in ISIS. Documentation indicates similar services to Prevocational Services were provided since date.

The assessment indicates this member list information according to assessment that applies to prevocational services. The notes indicate additional information noted.

The information submitted for members name and reviewed by Medical Services did not warrant the requested prevocational service. The review coordinator found that the member has a diagnosis of diagnoses. After review of the information, summary of RC's findings.

The case was forwarded to a peer reviewer for a medical necessity determination on date. The peer reviewer reviews all of the information that was submitted and relies on vocational expertise and judgment to determine medical necessity.

The peer reviewer evaluated this case in accordance with Iowa Administrative Code 79.9(2) which states the services covered by Medicaid shall:

i. Be consistent with the diagnosis and treatment of the patient's condition.
j. Be in accordance with standards of good medical practice.
k. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
l. Be the least costly type of service which would reasonably meet the medical need of the patient.

The peer reviewer also takes into consideration the Iowa Administrative Code governing the administration of the service:

enter the IAC

The peer reviewer did not approve the prior authorization request for prevocational services units for members name based on the following rationale:

- (Peer Reviewer's rationale)

date: The Case Manager was notified of Medical Service's determination via ISIS.

date: Correspondence was received from name requesting an appeal of the denial determination. Medical Services reviewed the information included in the appeal packet received to determine if new medical information was supplied. If the member or representative supplies additional information, then a review is completed on the current case. No additional information was supplied in this packet for review; therefore, no formal review was done at this time. Or additional information was reviewed and did not warrant a change in decision.
The Department maintains the original decision was correct.
Thank you for your consideration in this matter. If you have any questions, please contact me at 515-XXX-XXXX.
Sincerely,

Name, credentials

Title

Medical Services, Iowa Medicaid Enterprise

Enclosures:
Exhibit A: Appeal Memorandum
Exhibit B: Prevocational Services Criteria
Exhibit C: Prevocational Services Documentation
Exhibit D: Member Documentation
Exhibit E: Iowa Administrative Codes
Exhibit F: Individualized Services Information System (ISIS) screen shots (optional)
Exhibit G: Peer Reviewer Credentials

cc: Name
street address
city, state zip code

CM name
Agency name
street address
city, state zip code

TO: Iowa Department of Inspections and Appeals
Division of Administrative Hearings

ATTENTION: ALJ's name , Administrative Law Judge OR Administrative Assistant

FROM: Division of Medical Services, Name, Credentials

DATE: date

SUBJECT: Appeal Summary for members name,
Appeal Number number

An appeal was filed for members name regarding denial of Waiver serviceprovided on date of denial.

According to the Iowa Administrative Code applicable code; authorization will be approved for type of service when basis for medical necessity and services are medically necessary.

Upon review of documentation received from source of information on date, the Department has determined that waiver service are approvable. An approved notice of action for members name is to be completed by the case manager. Based on the above information, the Department requests that the appeal be dismissed.

Thank you for your consideration in this matter. If you have any questions, please contact me at 515-XXX-XXXX

Sincerely,

Name, credentials
Title
Medical Services, Iowa Medicaid Enterprise

cc: Name

street address
city, state zip code

CM name
Agency name
street address
city, state zip code

name, Income Maintenance Worker
County name County Department of Human Services
street address

RFP Reference:
6.2.4.2

Interfaces:
N/A

Attachments:
N/A

MED – Waiver Prior Authorization Peer-to-Peer Internal Quality Control

Purpose: Internal quality control (IQC) is a peer-to-peer review process completed on a percentage of reviews from the previous month.

Identification of Roles:
Manager or Lead Review Coordinator (RC) - Coordinates IQC and IQC reporting, determines percentage of reviews for IQC, reviews for inconsistencies.

Lead Review Coordinator (RC) - Disseminates random pull of reviews to complete to the RC's, completes selected reviews for IQC process, enters results into spreadsheet, takes concerns or inconsistencies to manager and completes IQC for appeal requests.

Review Coordinators (RC) – completes selected reviews for the IQC process.

Performance Standards:
Performance standards are not specified for this procedure.

Path of Business Procedure:
Step 1: By the fifth business day of the month the Lead RC will manually select random IQC reviews and assign to the RC to complete IQC.
Step 2: The manager or Lead RC takes a percentage of the reviews completed in the prior fiscal year and determines the monthly number of reviews that will have an IQC review.
Step 3: The manager or Lead RC will manually select a percentage of completed reviews based on the number of LOC reviews completed in the previous fiscal year, divided out to be reviewed monthly.

Step 4: Using a random sample selection method the Lead RC will pull reviews from the monthly waiver performance report**.**

Step 5: The Lead RC will determine by program the number of reviews; initial reviews and SSR reviews.

Step6: The Lead RC will pull a pre-determined number of reviews monthly.

Step 7: The Lead RC will provide each RC with the random sample of SID's to review.

Step 8: After the sample group is identified the Lead RC will distribute the list to the RC's to complete an IQC review and provides a date of completion requirement.

Step 9: The RC will complete the IQC review, evaluating the following:

a. Do you agree with the decision?
b. Was the criteria applied correctly?
c. If services were not able to be approved by the RC, was additional information requested?
d. Was the decision to utilize or not utilize physician review appropriate?
e. Was the review completed timely to meet DHS performance standards?

Step 10: The Lead RC will review spreadsheet and forward appropriate feedback to each RC insuring that corrections are made in a timely manner and provide educational training or other remediation as needed.

Step 11: In the IQC outcome report, the Lead RC will list: :\IQC\IQC reports\FY 20XX\IQC report FY 20XX

Step 12: The manager will provide IQC data for quarterly reporting.

Forms/Reports:

Waiver Prior Authorization
Internal Quality Control Questionnaire

Reviewer's Assigned Letter: Date:

Member's Name: Review Coordinator:

Type of Review:

Question	(Yes or No)	Comments
1. Do you agree with the decision?		
2. Was the criteria applied correctly?		
3. If services were not able to be approved by the RC was additional information requested?		
4. Was the decision to utilize or not utilize physician review appropriate?		
5. Was the review completed timely to meet DHS performance standards?		

*if the answer is no, please add a comment.

IQC Review Report FY12

Method: A total of # CDAC reviews were completed during (Month/year). (#) of these assessments were randomly
to have at least (#) reviews completed each quarter. The results are documented below:

Questions:	**Yes**	**No**
1. Do you agree with the decision?		
2. Was the criteria applied correctly?		
3. If services were not able to be approved, was additional information requested?		
4. Was the decision to utilize or not utilize physician review appropriate?		
5. Was the review completed timely to meet DHS performance standards?		

Trends:

	July xx	Aug xx	Sep xx	Oct xx	Nov xx	Dec xx	Jan xx	Feb xx	Mar xx	Apr xx	May xx	Jun xx
Percentage												
Total number of reviews for the month												

RFP Reference:
6.2.4.2

Interfaces:
N/A

Attachments:
N/A

MED – Service Plan Report Process

Purpose: To provide data regarding Service Plan counts for each month/quarter.

Identification of Roles:
Lead Review Coordinator (RC) or Manager – Compiles data for the monthly and quarterly reports.

Program Specialist – Proofs and completes the monthly and quarterly reports.

Performance Standards:
Although not contractually required, provide the required monthly and quarterly Waiver PA activity reports within ten business days from the end of the reporting period (month or quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in June.

Path of Business Procedure:
Step 1: Manager or designee accesses monthly data within OnBase, Report Services, Report Groups – All. Scroll down the list of options, select MED Service Plan Authorization. Select and run query.
Step 2: Manager or designee saves data as an excel spreadsheet in WPA>reports>FY 2013>Service Plan>data.
Step 3: Lead RC sorts data by Brain Injury and Intellectual Disability waivers for counts-Total, Accept, Revisions Needed, and Rejected. Lead RC eliminates lines that were not completed by WPA team members. Lead RC eliminates lines with "Additional information is required." "Accepted." "Accepted with a modification of services". A review of every line that has "rejected" is completed to ensure it isn't related to a WPA review. All WPA related reviews are included within reports.
Step 4: Open "Service Plan Monthly Report FYXX" saved in WPA>reports>FY 20XX. RC adds counts into Service Plan Monthly Report.
Step 5: Upon quarter end, the quarterly numbers of Service Plan review counts for Brain Injury and Intellectual Disability waivers are completed by Total, Accept, Revisions

Needed, and Rejected. Quarterly data is sent to Program Specialist to include within the Quarterly Report.

Forms/Reports:

	July	Aug	Sept	Month	Year to Date
Brain Injury Waiver					
Accept					
Revisions Needed					
Rejected					
Intellectual Disability Waiver					
Accept					
Revisions Needed					
Rejected					
Denial Reason					
Information Not Received					

Interfaces:
OnBase

RFP Reference:
6.2.4.2

Attachments:
N/A

MED – WPA Report Process

Purpose: To provide data regarding the WPA review counts for each month/quarter.

Identification of Roles:
Lead Review Coordinator (RC) or Manager – Compiles data for the monthly and quarterly reports.

Program Specialist – Proofs and completes the monthly and quarterly reports.

Performance Standards:

Provide the required monthly and quarterly Waiver PA activity reports within ten business days from the end of the reporting period (month or quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in June.

Path of Business Procedure:

Step 1: Lead RC or Manager accesses monthly data from Report Services in Report Groups- Medical Services WPA-MED WPA Timeliness Report.
Step 2: Lead RC saves data in WPA>Reports>FY 20XX>Monthly>data.
Step 3: Lead RC sorts data by initial reviews and subsequent service reviews for counts- Approved, Approved but modified, and Denied
Step 4: Lead RC sorts total counts by Adjudicated and Non-adjudicated reviews (these counts are not included in the quarterly report).
Step 5 Lead RC sorts by Denial Reason-Program Criteria not met and Information not received.
Step 6: Open "Working WPA Monthly Report FY 20XX" which is saved in WPA>reports>FY 20XX. Lead RC adds counts into WPA Monthly Report.
Step 7: Upon quarter end, total the quarterly numbers of the WPA reviews completed. Quarterly data is sent to Program Specialist to include within Quarterly Report.

Forms/Reports:

	July	Aug	Sept	Month	Year to Date
Number of Initial review					
Approved					
Approved but modified					
Denied					
Number of re-review					
Approved					
Approved but modified					
Denied					
Total Number of reviews received					
Adjudicated Reviews					
Nonadjudicated Reviews					
Denial Reason					
Program Criteria Not Met					
Information Not Received					

Interfaces:

RFP Reference:

6.1.3.4.1
6.1.3.4.3

Attachments:
N/A

MED – WPA D4 Report Process

Purpose: To provide data on the WPA D4 review counts for each month/quarter.

Identification of Roles:
Lead Review Coordinator (RC) or Manager – Compiles data for the monthly and quarterly reports.

Program Specialist – Proofs and completes the monthly and quarterly reports.

Performance Standards:
Although not contractually required, provide the required monthly and quarterly Waiver PA activity reports within ten business days from the end of the reporting period (month or quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in June.

Path of Business Process:
Step 1: Lead RC or Manager accesses monthly data from Report Services in Report Groups – ALL, MED Service Plan Authorization.
Step 2: Lead RC saves data in WPA>Reports>FY 20XX>D4.
Step 3: The data is sorted by Approved, Denied, Non-Adjudicated, and Technical Denial with total counts by RC.
Step 4: Open "D4 Monthly Report FY 20XX" is saved in WPA>reports>FY 20XX. Lead RC adds counts into D4 Monthly Report.
Step 5: Upon quarter end, total the quarterly numbers of the D4 reviews completed. Quarterly data is sent to Program Specialist to include within Quarterly Report.

Forms/Reports:

	July	Aug	Sept	Qtrly Total	Year to Date Total
Approved count					
Denial count					
Technical Denial count					
Non-adjudicated					

count					
total counts					

Interfaces:
ISIS

RFP Reference:
None identified.

Attachments:
N/A

MED – WPA-Service Plan Cost Savings Report Process

Purpose: To provide data on WPA Service Plan Cost Savings for each month/quarter.

Identification of Roles:
Lead Review Coordinator (RC) or Manager – Compiles data for the monthly and quarterly reports.

Program Specialist – Proofs and completes the monthly and quarterly reports.

Performance Standards:
Provide the required monthly and quarterly Waiver PA activity reports within ten business days from the end of the reporting period (month or quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in June.

Path of Business Procedure:
Step 1: Lead RC auto sums each RC's spreadsheet that are saved in WPA>Cost Savings to determine the cost savings.
Step 2: Lead RC adds all RC's monthly cost savings to "Overview of monthly cost savings FY 20XX" located in WPA>Cost Savings>FY 20XX.**Step 3:** Upon quarter end, total the quarterly cost savings for Service Plan reviews completed. Quarterly data is sent to Program Specialist to include within Quarterly Report.

Forms/Reports:

Month	AD cost savings	CDAC cost savings	EM cost savings	HVM cost savings	Prevoc cost savings	Service Plan cost savings	Total
July							
August							
September							
October							
November							
December							
January							
February							
March							
April							
May							
June							
TOTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Interfaces:

RFP Reference:
N/A
Attachments:
N/A

MED – Daily Supported Community Living D-4 Cost Savings Process

Purpose: To show cost savings for Daily Supported Community Living D-4 each quarter.

Identification of Roles:
Lead Review Coordinator (RC) – competes reviews and reviews data for the quarterly reports.

Review Assistant (RA) – completes support activities relative to tracking and compiling data.

Manager – monitors data, outcomes, and process to ensure consistency, efficiency and accuracy.

Program Specialist – Proofs and completes the monthly and quarterly reports.

Performance Standards:
Although not contractually required, provide the required monthly and quarterly HCBS PA activity reports within ten business days from the end of the reporting period (month or quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in the prior month of June.

Path of Business Procedure:
Step 1: Provider Cost Audit (PCA) sends the Daily Supported Community Living D-4 form to Medical Services to be approved, approved but modified, denied, technically denial or non-adjudicated. Review Coordinator (RC) gathers information as to whether or not it is to be approved, approved but modified, denied, technically denial or non-adjudicated. Once complete it is sent back to PCA in OnBase. PCA and/or the Department determines the amount of daily rate increase or denies the increase based on medical necessity or policy. The final rate is entered by PCA on the Projected Workload Tracker. The Projected Workload Tracker is sent to WPA weekly.
Step 2: The RA locates the adverse actions in the denied, technical denial, non-adjudicated and approved queues but only includes approved but modified. RC or Manager assists in determining if appropriate for cost savings calculation. Cost savings will be included within the calculation when related to medical necessity activity.
Step 3: The supported adverse actions are entered on the Cost Savings Master Tracker by the RA based on the directions below.

Date Reviewed	Member Name	SID	RC	Provider/Site

Notes	Rate Requested	Rate Approved	Monthly Cost Savings	# of months

Total Cost Savings	Date Sent to Final Review (FR)	Date Sent (letter to provider)	Queue (Denied, approved but modified, tech denials, non adjudicated)

Date Reviewed: Date reviewed by Medical Services
Member Name: Last Name, First Name
State ID: Member's ID found on D-4 and confirmed by ISIS
RC: Name of the Review Coordinator that completed the review
Provider/Site: Name of the Provider and site found on the D-4

Notes: Why Medical Services either denied, approved but modified and any other notes relevant to cost savings.

Rate Requested: The rate requested by the provider on the D-4 or from the Projected Workload Tracker.

Rate Approved: Final rate on the Projected Workload Tracker.

Monthly Cost Savings: Cost savings calculation formula is: Rate requested – rate approved = amount of daily savings. Amount of daily savings times thirty one (31 days) = monthly cost savings.

Number (#) of months: Enter number of months within service plan this rate is approved for within ISIS.

Total Cost Savings: Calculation formula for Monthly cost savings is: monthly amount X number of months = Total cost savings for the review.

Date Sent to Final Review (FR): Enter date from Projected Workload Tracker.

Date Sent (letter to Provider): Enter date from Projected Workload Tracker.

Queue: Enter the queue type of the adverse action; Denied, Approved-Approved But Modified, Technical Denials, or Non Adjudicated.

Step 4: RA will sort worksheet by cost savings within quarterly date range based on the final review date. RA will sum the total cost savings amounts = Quarterly cost savings for Daily Supported Community Living D-4.

Step 5: Upon quarter end, RA totals the quarterly data. Quarterly data is sent to Program Specialist to include within Quarterly Report.

Forms/Reports:
N/A

Interfaces:

RFP Reference:
N/A

Attachments:
N/A

MED – WPA Cost Savings Report Process

Purpose: To show WPA Cost Savings for each month/quarter.

Identification of Roles:
Lead Review Coordinator (RC) or Manager – Compiles data for the monthly and quarterly reports.

Program Specialist – Proofs and completes the monthly and quarterly reports.

Performance Standards:

Provide the required monthly and quarterly HCBS PA activity reports within ten business days from the end of the reporting period (month or quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in the prior month of June.

Path of Business Procedure:

Step 1: Lead RC or Manager accesses monthly data from Report Services in Report Groups- Medical Services WPA-MED WPA Cost Savings Report.
Step 2: Lead RC saves data in WPA>Cost Savings>FY 20XX>
Step 3: Lead RC sorts data by Assistive Device, Consumer Directed Attendant Care, Environment Modifications, Home and Vehicle Modifications, and Prevocational Services.
Step 4: Lead RC adds monthly cost savings to "Overview of monthly cost savings FY 20XX" located in WPA>Cost Savings>FY 20XX.
Step 5: Upon quarter end, total the quarterly cost savings for WPA reviews completed. Quarterly data is sent to Program Specialist to include within Quarterly Report.
Step 6: Upon fiscal year end, total annual cost savings. Annual cost savings is sent to Program Specialist to include within the Annual Cost Savings Report.

Forms/Reports:

Month	AD cost savings	CDAC cost savings	EM cost savings	HVM cost savings	Prevoc cost savings	Service Plan cost savings	Daily SCL (D4) Cost Savings	Total
July								
August								
September								
October								
November								
December								
January								
February								
March								
April								
May								
June								
TOTAL	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	

Interfaces:

N/A

RFP Reference:
6.1.3.4.1
6.1.3.4.3

Attachments:
N/A

MED – WPA Timeliness Report Process

Purpose: To provide data regarding WPA reviews completed within performance standards for each month/quarter.

Identification of Roles:
Lead Review Coordinator (RC) or Manager – Compiles data for the monthly and quarterly reports.

Program Specialist – Proofs and completes the monthly and quarterly reports.

Performance Standards:
Provide the required monthly and quarterly Waiver PA activity reports within ten business days from the end of the reporting period (month or quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in June.

Path of Business Procedure:
Step 1: Lead RC or Manager accesses monthly data stored in WPA>Reports>FY 20XX>Monthly>data>Month 20XX>Data Pull.
Step 2: Lead RC sorts data by the timeliness column.
Step 3: Lead RC provides the RC's with those reviews that were untimely to determine reason.
Step 4: Open "WPA Report Data Month-20XX" stored in WPA>Reports>FY 20XX>Monthly>Internal Monthly Reports.
Step 5: Lead RC adds timeliness counts into WPA Report Data.
Step 6: Upon quarter end, total the quarterly data. Quarterly data is sent to Program Specialist to include within Quarterly Report.

Forms/Reports:

	Timeliness Initials	% of Initial Timeliness	Timeliness SSR	% of SSR Timeliness	Total Timely	% Timely
Total=	**0**		**0**		**0**	

Interfaces:

RFP Reference:
6.1.3.4.1
6.1.3.4.3

Attachments:
N/A**MED – Waiver Prior Authorization Disruption of Business Plan**

Purpose: To provide procedures for the continuation of business in the event of inability to utilize electronic programming.

Identification of Roles:
Review Coordinator (RC) – responds to WPA requests. All activities will be noted in Onbase.

Review Assistant (RA) – receives WPA request, enters on spreadsheet, routes to the appropriate RC and sends notices to providers as needed. All activities will be noted in Onbase.

Manager – provides training and oversight for RC and RA.

Path of Business Procedure:
Step 1: The RA will receive WPA forms by fax.
Step 2: The RA will forward requests by telephone to the RC based on the criteria established by the manager.
Step 3: The RA will log calls and capture the following information:

a. Date received
b. Member name
c. Member SID
d. Caller name
e. Services requested

f. RC assigned

Step 4: The RC will document review determinations in a paper tool:

a. Date Received
b. Member Name
c. Member SID
d. Type of program request
e. Date additional information requested
f. Date additional information received
g. Date of PR
h. Status of request

Step 5: The RC will document review information following the review outline.

Step 6: The RC will enter review information in OnBase and ISIS when systems are restored.

Step 7: The RC will document compliance with criteria by utilizingpaper copies of criteria used in the IQC process.

Forms/Reports:

Following is the paper tool the RC will complete:

Date Rec'd	Member Name	Member SID	Service Requested	Date additional information requested	Date information received	Date of PR	Status of determination

Following is the Call Log Spreadsheet the RA will complete:

Date received	Date/Time RC contacted	Member name	Member SID	Caller Name	RC assigned	Services Requested

RFP Reference:

6.2.4.2

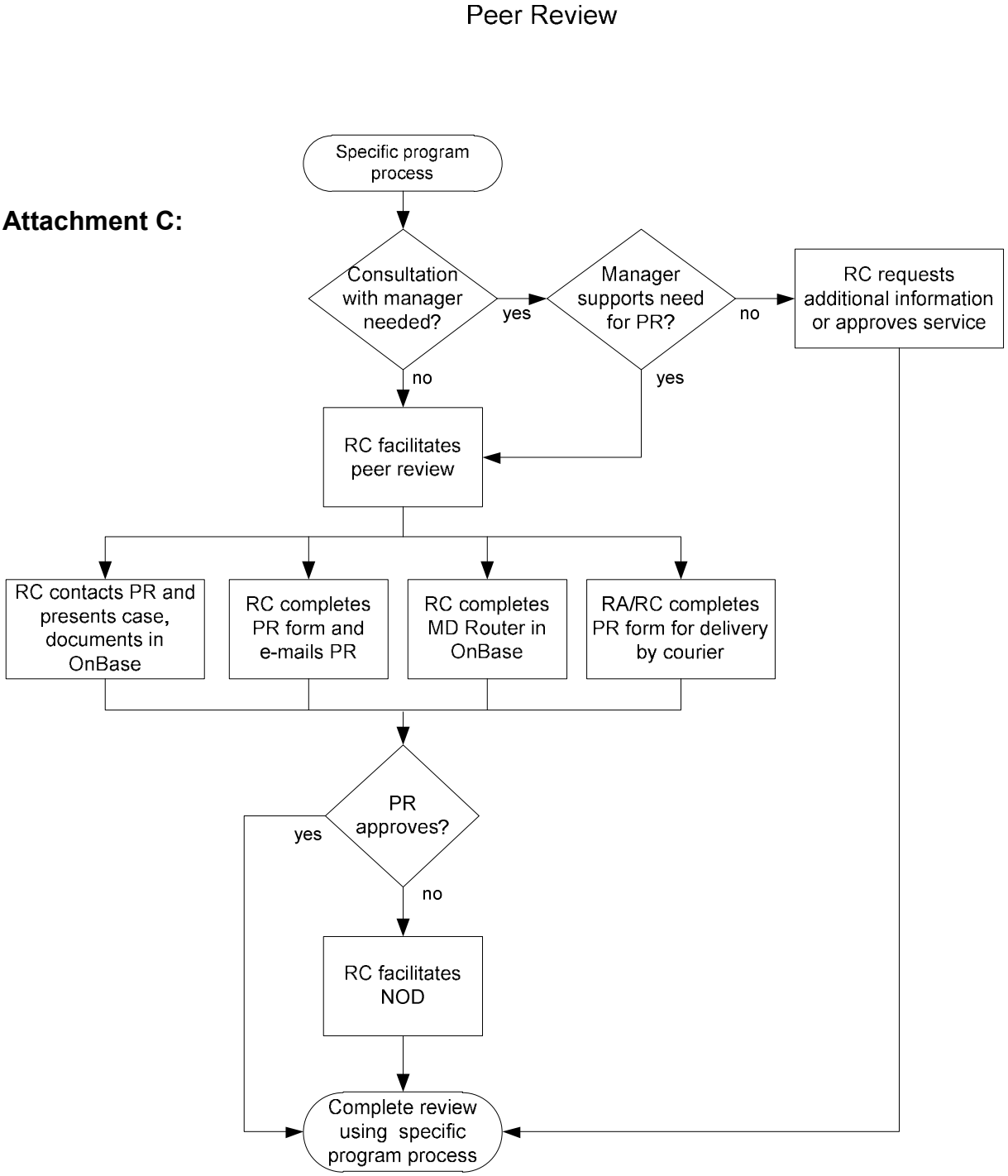
Interfaces:

N/A**Attachments:**

N/A

Attachment B:

Attachment C:



ADMINISTRATIVE LAW JUDGE APPEALS